PC3 Home Health Care

Quick Reference Guide

Key Points:

- TriWest Healthcare Alliance (TriWest) ***cannot pay fee-for-service*** under the Department of Veterans Affairs (VA) Patient-Centered Community Care (PC3) program, even if a Home Health Agency (HHA) previously directly billed VA in this fashion.
- An HHA who sees Veterans under PC3 needs to bill TriWest according to ***Medicare guidelines that are*** in place at the start of an episode.
- VA expects TriWest to be prepared to issue authorizations for new episodes of care and pay claims under the Patient-Driven Groupings Model (PDGM) as of Jan. 1, 2020.
- PC3 covers skilled nursing services for home health care, including home infusion when necessary, and skilled therapy services (PT/CT/ST).
- When completing the Request for Anticipated Payment (RAP) on the UB-04, HHAs should bill at minimum one penny, even though the Medicare requirement is zero.
- If a Veteran was previously provided care paid directly by VA, HHAs must initiate a **new** Outcome and Assessment Information Set (OASIS) assessment once the Veteran has been referred through PC3.

TriWest Authorized Care versus Directly Authorized VA Care

If VA transfers Veterans from **directly** authorized home health care to PC3, HHAs should be aware that **TriWest** – ***not the VA Medical Center (VAMC)*** – is the administrator, and care should be provided according to the guidelines defined in this Reference Guide. Additionally, TriWest is responsible for creating the authorization letter which defines the approved episode of care (in coordination with VA), and paying provider claims.

How to Initiate Home Health Care:

- A **VA clinician** can determine that services are needed and push an authorization to that VAMC's Community Care department. The appointment will be scheduled by the VAMC Community Care staff. A confirmed appointment from VAMC to TriWest will generate an authorization letter for the HHA.
    - TriWest cannot generate an authorization for non-credentialed HHAs.
- If a **community provider** believes that a Veteran needs skilled home health care (not hospice), providers should submit a Request for Services (RFS) to get care authorized. VA typically has 14 days to review and approve this request. Once approved, TriWest will generate an authorization letter for the HHA.
- For Veterans being discharged from inpatient care, **the ordering physician or the facility** must submit an URGENT RFS prior to discharge. Once VA has approved the care, TriWest will generate an authorization letter.

- HHAs should verify a facility has taken this step. All care *must be pre-authorized*.

Home Health Documentation

Once an HHA has been contacted (via phone or written authorization letter), VA has already initiated transfer of the Veteran's care to TriWest's administration under PC3.

With transition to PC3:

- Begin following the current Medicare model immediately.
- Discontinue fee-for-service billing to the VAMC once the VA authorization ends and the PC3 authorization from TriWest begins.
- After closing out the VA episode of care, initiate a new episode of care (EOC), including a new OASIS assessment.
- Create a plan of care from the OASIS assessment and submit it to the authorizing VAMC.
  - **Within three business days** from the start of care – submit the initial plan of care (CMS 485 Form). The 485 should be signed by the clinician that performed the initial evaluation (e.g., a registered nurse, physical therapist, occupational therapist, or a physician).
  - It is not necessary to wait until the ordering physician signs the plan. It is often a VA physician that needs to sign, and by promptly submitting the 485 to TriWest or VA, the physician signature is expedited.
  - **Within five business days** of completing care, submit an end EOC record (a.k.a., discharge summary).
- TriWest is required by contract to follow Medicare as it pertains to billing practices only.
  - Veterans admitted to home health services under a TriWest authorization are not required to meet Medicare's skilling criteria. This will remain the same after the implementation of PDGM.
    - There is no requirement for homebound status, face-to-face documentation, skilled need certification, or the Medicare Provider and Supplier enrollment (this is the Provider, Enrollment, Chain and Ownership System, a.k.a. PECOS, enrollment) by the ordering physician.
- Bill TriWest's claims processor, PGBA, on a UB-04 or electronic equivalent according to Medicare guidelines. Per contractual requirements, TriWest ***cannot pay fee-for-service***.

Additional Billing Guidelines

HHAs also need to follow these additional billing guidelines:

- After completing the OASIS assessment, submit a RAP claim using ***Type of Bill Code 322*** to PGBA.
- When completing the RAP on the UB-04, HHAs should bill at minimum one penny, even though the Medicare requirement is zero.
- At the end of the episode of care, submit final billing using ***Type of Bill Code 329***.
- OASIS assessment details reveal a code required for billing. If the OASIS data/code is not included on the claim, then the claim will be denied.
- If a home health claim needs to be cancelled, you must submit a claim with a Type of Bill Code 328.

- All HHAs should make their best efforts to submit claims to PGBA within 30 days.
- PC3 has a 180-day timely filing limit. Please ensure your claims are submitted within this timeframe.
- In compliance with Medicare policy, claims must contain the ***code for the county*** of service. Submit value code "85" with the state and county code of the place of residence where the home health service was delivered in the amount field.

Low Utilization Payment Adjustment (LUPA) Claims

- TriWest follows Medicare guidelines that are current at the start of care for LUPA claims.

To learn more about Medicare's Prospective Payment System (PPS) for Home Health, please visit the Centers for Medicare and Medicaid (CMS) website.

Requesting Additional Care

- If Veterans need an additional *episode* of home health care, please submit a RFS to have these services approved prior to rendering any care.
- All skilled services are included in the original home health authorization, so you do not need to submit a RFS with an approved episode. Orders must come from the VA physician or community physician and not through TriWest.

When is TriWest/VA Primary? Veterans may elect to use their Veteran/VA benefits **over** Medicare, even if Medicare is listed as the primary payer. If you receive an authorization from TriWest, the Veteran has elected to use his or her VA benefits. For these authorizations, VA is primary. Claims should be sent to PGBA. Veteran benefits **cannot** pay secondary to Medicare.

NOTE: Unskilled care, also known as Home Health Aide or Companion Care, is NOT available under PC3. TriWest is paying claims for this type of care only under the Community Care Network (CCN).